Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: CYPRESS FAIRBANKS MEDICAL CENTER C/O LAW OFFICE OF P MATTHEW O'NEIL 6514 MCNEIL DRIVE BLDG 2 SUITE 201 AUSTIN TX 78729	MFDR Tracking #: M4-11-1763-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: WAL MART ASSOCIATES INC Box #: 53	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As set forth in the attached billing and records, the claimant I this case was admitted and received inpatient hospital procedures, specifically relating to an on-the-job injury. The treatment involved out-patient physical therapy visits. However, the Carrier has only paid for a portion of the services. As discussed below, the Carrier authorized all the treatment provided and subsequently billed. As required by law, Cypress Fairbanks Medical Center (hereinafter referred to as "the Hospital" billed its usual and customary charges for the medical services. The total amount billed was $2,301.83. The charges are broken down on the bill and itemized billing as attached hereto. Thus, this out-patient medical service utilized various services and supplies at the Hospital and the amount billed for the services was fair and reasonable at the time and placed provided for this patient. As shown by the attached documentation, payment for only a portion of the services and physical therapy sessions were paid. For the remainder, CPT code 97113 was denied for exceeding precertification/authorization. However, the Hospital indeed obtained a preauthorization number of MITC2010011 prior to the services being provided. Thus, the services were well within the scope of the authorization for this compensable injury. Additional payment for the remaining services with the expected reimbursement being $377.58 remains due and owed. Thus, the Hospital also seeks a finding by the Division that the carrier also owes interest as required by law and Division rules."

Amount in Dispute: $377.58

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the attached preauthorization letter, which indicates a negotiated service 3 x 4 weeks for procedures 97110, 97140, 97035, G0283; Combination 4 Total units per session. Cypress Fairbanks Medical Center billed for procedure 97113; however, this procedure was not requested for preauthorization and is not entitled to reimbursement. No additional payment is recommended at this time."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
02/02/10, 02/05/10, 02/08/10	Outpatient Physical Therapy – CPT Code G0283GP	(54.32÷ 36.0791) x $12.10 = $18.22 x 3 units = $54.65 - $54.88 (carrier payment)	377.58	$0.00
02/02/10, 02/05/10, 02/08/10	Outpatient Physical Therapy – CPT Code 97110GP	(54.32÷ 36.0791) x $27.81 = $40.97 x 9 units = $390.52 - $432.40 (carrier payment)		$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital outpatient services.

This request for medical fee dispute resolution was received by the Division on June 21, 2010.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - W1 – Workers Compensation State Fee Schedule adjustment.
   - 170 – Reimbursement is based on the outpatient/inpatient fee schedule.
   - W5 – Request of recoupment for an overpayment made to a health care provider.
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - 5081 – Reduction or denial of payment resulting after a reconsideration was complete.
2. Division rule at 28 TAC §134.403(h) states that for medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.
3. The disputed services are CPT Codes G0283-GP and 97110-GP. According to Medicare, hospital outpatient physical therapy services are Status A codes. Status A codes are paid under a fee schedule or with a prospectively pre-determined rate. According to the preauthorization approval MITC20100119_38761 the negotiated preauthorized services were 97110, Initial Post-op Physical Therapy Left Knee, 3xwk x 4 wks; Combination 4 Total Units per Session. 75% Active Therapy; 97140, Manual Therapy Left Knee; 97035, Ultrasound Therapy left knee and G0283, Electrical Stimulation left knee. In accordance with 28 TAC Section §134.203, the division concludes that the Requestor has been reimbursed for these procedures and additional reimbursement is not recommended.
4. Although CPT Code 97113 was mentioned in the Requestor's position summary it was not listed as one of the codes in dispute and is not considered part of this review.
5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
   (1) No documentation was found to support a contractual agreement between the parties to this dispute; and
   (2) MAR can be established for these services.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031(c), the Division concludes that the requestor is not due additional payment. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307, §134.203, §134.403
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	March 14, 2011 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.